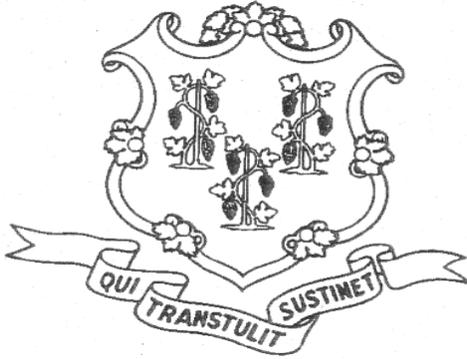


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Trinity Hill Care Center, LLC	
Address (No. & Street, City, State, Zip Code) 151 Hillside Avenue, Hartford, CT 06016	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> NurseFac-Aids	
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 2222-C	RHNS	NurseFac-Aids AIDS	Medicare Provider 07-5268
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Medicaid Provider Numbers:	CCNH 9555	RHNS	ICF-IID 49553
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**For Department Use Only**

Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Number Assigned	Signed and Notarized	Date Received

### General Information

Name of Facility (as licensed) Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2021	Page 1	of 37
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#### Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Trinity Hill Care Center, LLC [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Yong Crandall			Printed Name (Owner) Chris Wright	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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State of Connecticut  
**Department of Social Services**  
 55 Farmington Avenue, Hartford, Connecticut 06105

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Trinity Hill Care Center, LLC		Period Covered:	From 10/1/2020	To 9/30/2021
Address of Facility 151 Hillside Avenue, Hartford, CT 06016				
Report Prepared By iCare Management, LLC		Phone Number 860-570-2140	Date 2/15/2022	
Item	Total	CCNH	RHNS	NurseFac- Aids
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

**DO NOT include Fringe Benefit Costs.**

## General Information and Questionnaire

### Type of Facility - Organization Structure

	Phone No. of Facility 860-951-1060	Report for Year Ended 9/30/2021	Page 2	of 37
Name of Facility (as shown on license) Trinity Hill Care Center, LLC		Address (No. & Street, City, State, Zip) 151 Hillside Avenue, Hartford, CT 06016		
License Numbers:	CCNH 2222-C	RHNS	NurseFac-Aids AIDS	Medicare Provider No. 07-5268
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input checked="" type="checkbox"/> NurseFac-Aids				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No           If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator Yong Crandall		Nursing Home Administrator's License No.:	002046	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire  
 Partners/Members**

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2021	Page 3	of 37
Legal Name of Partnership/LLC Trinity Hill Care Center, LLC		Business Address 151 Hillside Avenue, Hartford, CT 06016		State(s) and/or Town(s) in Which Registered CT	
Name of Partners/Members	Business Address	Title		% Owned	
V. Robert Salazar	2500 18th Street, Suite 200, Denver, CO 80211	Member		31.3	
David Sebbag	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		21.4	
Ari Krausz	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		21.3	
Solomon Melamed	245 South Benton Street, Suite 100, Lakewood, CO 80226	Member		1	
Christopher Wright	341 Bidwell Street, Manchester, Ct 06040	Member		5	
Premier First Investors	245 S. Benton Street, Lakewood, CO 80226	Member		10	
Global World Investors	245 S. Benton Street, Lakewood, CO 80226	Member		10	

## General Information and Questionnaire Corporate Owners

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2021	Page 3A	of 37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated	

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each

Names of Stockholders Owning at Least 10% of Shares	Business Address	Title	No. Shares Held by Each





## General Information and Questionnaire

### Basis for Allocation of Costs

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2021	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist ( <i>See listing page 13</i> )
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required?       Yes       No      If "No," explain fully why such allocation was not made.

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

Yes       No      If "No," explain fully why such allocation was not made.

### General Information and Questionnaire Leases (Excluding Real Property)

**Operating Leases** - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2021		Page of 6   37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909	<input type="radio"/>	<input checked="" type="radio"/>	Time Clocks and Payroll Punch Equip	06/01/10	60 months & automatic	8,332	8,332	
GE Capital C/O Wells Fargo, P.O.Box 41564, Philadelphai, PA 19101	<input type="radio"/>	<input checked="" type="radio"/>	Copier	03/05/14	48 months & automatic	10,237	10,237	
Neopost USA Inc, 25880 Network Place, Chicago, IL 60673	<input type="radio"/>	<input checked="" type="radio"/>	Postage Rental	04/16/13	Month to month	714	714	
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input checked="" type="radio"/> No	<b>Total ***</b>
								19,283

\* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.  
 \*\* Attach copies of newly acquired leases.  
 \*\*\* Amount should agree to Page 22, Line 6e.

**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2021	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:  
 Accrual     Cash     Modified Cash

Is the accounting basis for this period the same as for the previous period?     Yes     No    If "No," explain.

**Independent Accounting Firm**

Name of Accounting Firm 1 O'Connor, Davies LLP 2 3 4	Address (No. & Street, City, State, Zip Code) 100 Great Meadow Road, Ste 401, Wethersfield, CT 06109
--	---

Services Provided by This Firm (*describe fully*)

1 Taxes, financial statements, accounting support	\$ 9,460
2	\$
3	\$
4	\$
<b>Charge for Services Provided</b>	
	\$ 9,460

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    15D

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 iCare Health Management, LLC 2 Starble and Harris 3 Durant Nichols / Robinson & Cole, LLP 4 Various others (American Arbitration , Various Arbitration, Murtha Cullina, Jackson Lewis)) 5 Starble and Harris, iCare Health Management LLC	Telephone Number 860-570-2140 860-678-7775 860-275-8200 860-678-7775 & 860-570-2140
---	---

Address (*No. & Street, City, State, Zip Code*)

1 341 Bidwell Street, Manchester CT
2 32 Main Street, Avon, CT
3 280 Trumbull St, Hartford, CT
4
5 32 Main Street, Avon, CT & 341 Bidwell Street, Manchester CT

Services Provided by This Firm (*describe fully*)

1 Lease and contract issues, general legal advice, Labor Law	\$ 3,876
2 Lease and contract issues, general legal advice, union funds advice	\$
3 Employment law, arbitrations, contract negotiations	\$
4 Employment Arbitrations, healthcare law & Conservatorships	\$ 3,191
5 Collections	\$
<b>Charge for Services Provided</b>	
	\$ 7,067

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    15E

**Schedule of Resident Statistics**

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2021				Page 8	of 37			
	Total All Levels	Total CCNH Level	Total RHNS Level	Total NurseFac-Aids	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	NurseFac-Aids	Total	CCNH	RHNS	NurseFac-Aids	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	144	114		30	144	114		30					
B. On last day of THIS report period	144	114		30					144	114			30
2. Number of Residents													
A. As of midnight of PREVIOUS report period	131	103		28	131	103		28					
B. As of midnight of THIS report period	115	92		23					115	92			23
3. Total Number of Days Care Provided During Period													
A. Medicare	632	632			374	374			258	258			
B. Medicaid (Conn.)	42,266	33,791		8,475	31,946	25,527		6,419	10,320	8,264			2,056
C. Medicaid (other states)													
D. Private Pay													
E. State SSI for RCH													
F. Other (Specify) Insurance	72	72			15	15			57	57			
G. Total Care Days During Period (3A thru F)	42,970	34,495		8,475	32,335	25,916		6,419	10,635	8,579			2,056
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days													
B. Other Bed Reserve Days													
5. <b>Total Resident Days (3G + 4A + 4B)</b>	42,970	34,495		8,475	32,335	25,916		6,419	10,635	8,579			2,056

**Annual Report of Long-Term Care Facility**

**Schedule of Resident Statistics (Cont'd)**

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C			Report for Year Ended 9/30/2021			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	NurseFac-Aids	Lost			Gained			CCNH	RHNS	NurseFac-Aids	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days										CCNH	RHNS	NurseFac-Aids	
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH		CCNH	RHNS	CCNH	RHNS	NurseFac-Aids	R.C.H.	ICF-MR				
No. of Residents	3		88			1	23						
Per Diem Rate													
a. One bed rm.	478.00		342.00			417.00	372.00						
b. Two bed rms.													
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments										TOTAL	CCNH	RHNS	NurseFac-Aids
A. Medicare - Part B										3,198	2,567		631
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments										1,719	1,380		339
2. Restorative Treatments										1,844	1,480		364
C. Other										2,442	1,960		482
D. <b>Total Physical Therapy Treatments</b>										9,203	7,388		1,815
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B										809	649		160
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments										180	144		36
2. Restorative Treatments										138	138		
C. Other										276	194		82
D. <b>Total Speech Therapy Treatments</b>										1,403	1,126		277
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B										1,626	1,305		321
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments										750	602		148
2. Restorative Treatments										1,405	1,128		277
C. Other										1,494	1,199		295
D. <b>Total Occupational Therapy Treatments</b>										5,275	4,235		1,040

## Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

## Report of Expenditures - Salaries &amp; Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Trinity Hill Care Center, LLC	2222-C	9/30/2021	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	NurseFac-Aids	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	114,433	1,380			28,115	690
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	199,606	8,782			99,803	4,391
5. Dietary Service						
a. Head Dietitian	589	40			145	11
b. Food Service Supervisor	88,316	1,644			21,698	433
c. Dietary Workers	433,552	19,708			106,518	5,186
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	271,488	15,112			135,744	7,556
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance						
b. Other Maintenance Workers	25,007	1,499			12,503	749
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	81,239	4,182			40,619	2,091
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	146,877	2,788			73,439	1,394
b. RN						
1. Direct Care	330,646	6,034			180,937	4,059
2. Administrative**	230,480	5,318			115,240	2,659
c. LPN						
1. Direct Care	1,147,386	34,156			180,529	6,352
2. Administrative**						
d. Aides and Attendants	1,621,456	84,658			230,614	13,185
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	150,308	6,037			36,929	1,589
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	129,565	4,913			31,832	1,293
n. Marketing						
o. Other (Specify) See Attached Schedule	178,561	8,798			69,435	3,673
<i>A-13. Total Salary Expenditures</i>	5,149,506	205,048			1,364,100	55,310

\* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

\*\* Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

\*\*\* This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.



**Schedule A1 - Salary Information for Operators/Owners; Administrators,  
Assistant Administrators and Other Related Parties\***

Name of Facility				License No.	Report for Year Ended			Page	of	
Trinity Hill Care Center, LLC				2222-C	9/30/2021			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	NurseFac-Aids							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

\* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

\*\* Include **all** employment worked during the cost year.

**Schedule A1 - Salary Information for Operators/Owners; Administrators,  
Assistant Administrators and Other Related Parties\***

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Trinity Hill Care Center, LLC				2222-C	9/30/2021			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	NurseFac-Aids							
<b>Section III - Administrators***</b>										
Yong Crandall	93,515		28,115	same as employees less union funds	Administrator	1,886	A2			
George Kingston	20,918			same as employees less union funds	Administrator	184	A2			
				same as employees less union funds	Administrator		A2			
<b>Section IV - Assistant Administrators</b>										

\*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

\*\* Include **all** other employment worked during the cost year.

\*\*\* If more than one Administrator is reported, include dates of employment for each.

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of		
Trinity Hill Care Center, LLC	2222-C	9/30/2021	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	RHNS	Hours	NurseFac-Aids	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist						
3. Pharmacist	16,472	166			4,047	41
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	95,044	1,821				
b. Other						
6. Social Worker	4,575	53			1,124	14
7. Recreation Worker	1,622	2+Cable			811	2+Cable
8. Physicians						
a. Medical Director (entire facility)	54,000	236			64,992	490
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify) Physician Care Contract Services	11,317	14			2,781	4
9. Speech Therapist						
a. Resident Care	22,629	433				
b. Other						
10. Occupational Therapist						
a. Resident Care	89,679	1,718				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	146,192	1,886				
2. Administrative***	(90,919)	(1,316)				
b. LPN						
1. Direct Care	69,799	969				
2. Administrative***						
c. Aides	13,086	398				
d. Other						
12. Other (Specify) See Attached Schedule	162,664	3,128			71,893	1,591
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>596,160</b>	<b>9,506</b>			<b>145,647</b>	<b>2,139</b>

\* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

\*\* This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

\*\*\* Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

**Report of Expenditures**  
**Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis\***

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C		Report for Year Ended 9/30/2021	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Tocuhpoints Therapy	Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Pharm Scripts	Pharmacy Contract	<input type="radio"/>	<input checked="" type="radio"/>			
Guardian Consulting Srv	Pharmacy Consulting	<input type="radio"/>	<input checked="" type="radio"/>			
Healthdrive Physician Services	Audiology, Dental and Podiatry	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Johnson Fielding III	Med Dir	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Villanueva Elmo	Med Dir	<input type="radio"/>	<input checked="" type="radio"/>			
Dr Tress	HIV Med Dr	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

\* Use additional sheets if necessary.  
 \*\* Refer to Page 4 for definition of related.

**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2021		15	37
Item	Total	CCNH	RHNS	NurseFac-Aids	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 142,547	113,114			29,433
2. Disability Insurance	\$				
3. Unemployment Insurance	\$				
4. Social Security (F.I.C.A.)	\$ 550,063	436,486			113,578
5. Health Insurance	\$ 1,061,362	842,211			219,151
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 377,927	299,892			78,035
8. Uniform Allowance	\$				
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 46,501	36,899			9,602
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 120,004	120,004			
d. Accounting and Auditing	\$ 9,460	7,594			1,866
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 7,067	5,673			1,394
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$				
g. Office Supplies	\$ 18,485	12,323			6,162
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 21,423	17,197			4,225
2. Cellular Phones	\$ 1,157	929			228
i. Appraisal ( <i>Specify purpose and         attach copy</i> )*	\$				
j. Corporation Business Taxes ( <i>franchise tax</i> )	\$				
k. Other Taxes ( <i>Not related to property - See Page 22</i> )					
1. Income*	\$				
2. Other ( <i>Specify</i> ) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 895,852	719,163			176,689
<b>Subtotal</b>	\$ 3,251,848	2,611,486			640,363

\* Facility should self-disallow the expense on Page 28 of the Cost Report.

(Carry Subtotals forward to next page)



### C. Expenditures Other Than Salaries (cont'd) - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2021		16	37
Item	Total	CCNH	RHNS	NurseFac-Aids	
<b>Subtotals Brought Forward:</b>	3,251,848	2,611,486		640,363	
<b>l. Travel and Entertainment</b>					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	1,400	1,124	276	
3. Gifts to Staff and Residents	\$	72	58	14	
4. Employee Travel	\$	1,892	1,519	373	
5. Education Expenses Related to Seminars and Conventions	\$	853	685	168	
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$				
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
<b>m. Other Administrative and General Expenses</b>					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$	9,315	7,478	1,837	
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	7,550	6,061	1,489	
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	5,012	4,023	988	
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	9,777	7,849	1,928	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	1,502	1,206	296	
10. Contributions*** See Attached Schedule	\$	1,438	1,154	284	
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$	128,246	85,498	42,749	
12. Administrative Management Services**	\$	457,716	367,440	90,276	
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	46,332	37,195	9,138	
<b>C-14 Total Administrative &amp; General Expenditures</b>	<b>\$</b>	<b>3,922,953</b>	<b>3,132,774</b>	<b>790,179</b>	

\* Do not include Subscriptions, which should go in item 9.

\*\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

\*\*\* Facility should self-disallow the expense on Page 28 of the Cost Report.

## Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	NurseFac-Aids
MEALS	\$ -		\$ -
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

## Schedule of Other Advertising

Description	CCNH	RHNS	NurseFac-Aids
COMMUNICATIONS SPECIAL EVENTS	\$ 6,061		\$ 1,489
<b>Total Other Advertising</b>	\$ 6,061	\$ -	\$ 1,489

## Schedule of Dues

Description	CCNH	RHNS	NurseFac-Aids
ALTCFM			
CAHCF Dues	\$ 7,849		\$ 1,928
OTHER DUES			
<b>Total Dues</b>	\$ 7,849	\$ -	\$ 1,928

## Schedule of Contributions

Description	CCNH	RHNS	NurseFac-Aids
CONTRIBUTIONS	\$ 1,154		\$ 284
<b>Total Contributions</b>	\$ 1,154	\$ -	\$ 284

## Schedule of Other Administrative and General

Description	CCNH	RHNS	NurseFac-Aids
SOCIAL SERVICE SUPPLIES	\$ -		\$ -
SOC SVC MINOR EQUIPMENT	\$ -		\$ -
ADMINISTRATIVE MINOR EQUIPMENT	\$ 2,584		\$ 635
EMPLOYEE RELATIONS	\$ 1,191		\$ 293
EMPLOYEE RELATIONS-OTHER	\$ 132		\$ 32
PERMITS & LICENSES	\$ 1,933		\$ 475
VOLUNTEER EXPENSE	\$ -		\$ -
BANK FEES	\$ 2,863		\$ 704
CMS REVISIT USER FEES	\$ -		\$ -
PENALTIES	\$ 25,689		\$ 6,311
LATE FEES	\$ 902		\$ 222
INTERNET EXPENSES	\$ 1,899		\$ 466
Rounding	\$ 3		
<b>Total Other Administrative and General</b>	\$ 37,195	\$ -	\$ 9,138

### Schedule C-1 - Management Services\*

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2021	Page 17	of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #	
iCare Management, LLC/iCare Health Management, LLC	457,716	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12	
iCare Management, LLC/iCare Health Management, LLC	189,733	MANAGEMENT FEES- DIRECT CARE	Pg 20 j	
iCare Management, LLC/iCare Health Management, LLC	47,062	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j	

\* In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.

**C. Expenditures Other Than Salaries (cont'd) - Dietary Basis for Allocation of Costs (See Note on Page 5)**

Name of Facility Trinity Hill Care Center, LLC		License No. 2222-C	Report for Year Ended 9/30/2021		Page 18	of 37
Item	Total	CCNH	RHNS	NurseFac-Aids		
2. Dietary						
a. In-House Preparation & Service						
1. Raw Food	\$ 262,351	210,607			51,744	
2. Non-Food Supplies	\$ 32,361	25,978			6,383	
3. Other (Specify) _____ DIETARY SUPPLEMENTS	\$ 11,021	8,847			2,174	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ (23,629)	(18,969)			(4,660)	
c. Other (Specify) _____ DIETARY MINOR EQUIPMENT	\$ 2,436	1,955			480	
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 284,539</b>	<b>228,419</b>			<b>56,120</b>	
2E. Dietary Questionnaire	Total	CCNH	RHNS	NurseFac-Aids		
F. Resident Meals: Total no. of meals served per day:*	353	353				
G. Is cost of employee meals included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No				
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.		
K. Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)						
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.		
N. Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.		
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)						

\* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

**C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs**  
**(See Note on Page 5)**

Name of Facility		License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC		2222-C	9/30/2021	19	37
Item		Total	CCNH	RHNS	NurseFac-Aids
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. \$				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	53,656	35,771		17,885
c. Other (Specify) LAUNDRY MINOR EQUIPMENT	\$	461	308		154
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	<b>\$</b>	<b>54,117</b>	<b>36,078</b>		<b>18,039</b>
<b>3E. Laundry Questionnaire</b>					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

\* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.  
 All allocations should add to total recorded in 3D.

\*\*\* Pounds of Laundry only required for multi-level facilities.

**C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care  
 Basis for Allocation of Costs (See Note on Page 5)**

Name of Facility		License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC		2222-C	9/30/2021		20	37
Item			Total	CCNH	RHNS	NurseFac-Aids
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
	a. In-House Care					
	1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )	Amt. \$	27,887	18,591		9,296
	b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )	Sq. Ft. Serviced by Personnel				
		Amt. \$	40,518	27,012		13,506
	C. Other ( <i>Specify</i> )		\$			
	HOUSEKEEPING MINOR EQUIPMENT					
4D.	<b>Total Housekeeping Expenditures</b> (4a + b + c)		\$ 68,405	45,603		22,802
5.	Resident Care (Supplies)**					
	a. Prescription Drugs***					
	1. Own Pharmacy		\$			
	2. Purchased from PHARMACY		\$ 56,731	56,731		
	b. Medicine Cabinet Drugs		\$ (13,434)	(10,785)		(2,650)
	c. Medical and Therapeutic Supplies		\$ 146,165	117,337		28,828
	d. Ambulance/Limousine***		\$			
	e. Oxygen					
	1. For Emergency Use		\$ 784	784		
	2. Other***		\$			
	f. X-rays and Related Radiological Procedures***		\$ 1,306	1,306		
	g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )		\$			
	h. Laboratory***		\$ 20,463	20,463		
	i. Recreation		\$			
	j. Direct Management Services*		\$ 189,733	152,312		37,421
	k. Indirect Management Services*		\$ 47,062	37,780		9,282
	l. Other (Specify)**** See Attached Schedule		\$ 52,369	38,647		13,721
5M.	<b>Total Resident Care Expenditures</b> (5a - 5j)		\$ 501,178	414,575		86,603

\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

\*\* Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

\*\*\* Facility should self-disallow the expense on Page 29 of the Cost Report.

\*\*\*\* ICFMR's should provide a detailed schedule of all Day Program Costs.

## Schedule of Other Resident Care

Description	CCNH	RHNS	NurseFac-Aids
NURSING ADMIN SUPPLIES	\$ 5,187		\$ 1,274
NURSING MINOR EQUIP	\$ 2,937		\$ 722
MEDICAL RECORDS SUPPLIES	\$ (307)		\$ (75)
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
NON-COVERED PPS DR. VISITS	\$ -		\$ -
RESIDENT CARE SUPPLIES	\$ -		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 7,061		\$ 1,735
PERSONAL CARE SUPPLIES	\$ 173		\$ 43
INCONTINENCY SUPPLIES	\$ -		\$ -
VACCINE RESIDENTS	\$ 941		\$ -
PATIENT SPECIAL NEEDS	\$ -		\$ -
PHYSICAL THERAPY SUPPLIES	\$ -		\$ -
PHYSICAL THERAPY EQUIPMENT RENT	\$ -		\$ -
PHYSICAL THERAPY MINOR EQUIPMENT	\$ -		\$ -
OCCUPATIONAL THERAPY SUPPLIES	\$ -		\$ -
OCCUPATIONAL THERAPY EQUIP RENTAL	\$ -		\$ -
OCCUPATIONAL THERAPY MINOR EQUIP	\$ -		\$ -
SPEECH THERAPY SUPPLIES	\$ -		\$ -
SPEECH THERAPY EQUIPMENT RENT	\$ -		\$ -
SPEECH THERAPY MINOR EQUIPMENT	\$ -		\$ -
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 8,598		\$ 4,299
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ 78		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	\$ -		\$ -
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 5,781		\$ 2,890
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 1,010		\$ 505
ACTIVITIES SUPPLIES	\$ 1,537		\$ 769
ACTIVITIES MINOR EQUIPMENT	\$ -		\$ -
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ 675		\$ 338
STRIKE COSTS NON REIMBURSABLE	\$ 4,976		\$ 1,223
COVID NON REIMBURSABLE	\$ -		\$ -
<b>Total Other Resident Care</b>	<b>\$ 38,647</b>	<b>\$ -</b>	<b>\$ 13,721</b>

**Report of Expenditures**  
**Schedule C-2 - Individuals or Firms Providing Services by Contract \***

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2021			Page of 21   37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	NurseFac-Aids	Pg	Line
Health Services Group	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Housekeeping Services	40,518			20	4b
Health Services Group/Unitex Textile Rental Services	3220 Tillman Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Laundry Services	53,656			19	3b
Eagle Elevator		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Elevator Contract	6,126			22	6F
Brightview Landscapes LLC/MLG Landscaping LLC		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Snow Removal/Landscaping	15,295			22	6F
All Waste Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Trash removal	32,410			22	6F
American HealthTech		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Software Maintenance Contract	17,154			16	M11
Automatic Data Processing	P.O. Box 9001006, Louisville, KY 40290	<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Payroll Services	46,228			16	M11
National Datacare Corp		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Resident Trust Software	4,251			16	M11
Prime Care Technologuy services		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Computer Consulting Services	35,903			16	M11
Priotiry Express		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Courier Services	2,982			16	M11
Point Right Inc		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Nursing Software	4,697			16	M11
Facility Complain		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR	Plant Contract Services	157,446			22	6F
		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR						
		<input type="radio"/>	<input checked="" type="radio"/>	VENDOR						

\* List all contracted services over \$10,000. Use additional sheets if necessary.

\*\* Refer to Page 4 for definition of related.

\*\*\* Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

### C. Expenditures Other Than Salaries (cont'd) - Maintenance and Property

Name of Facility	License No.	Report for Year Ended			Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2021			22	37
Item	Total	CCNH	RHNS	NurseFac-Aids		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 32,243	21,496			10,748	
b. Heat	\$ 40,448	26,965			13,483	
c. Light & Power	\$ 69,751	46,501			23,250	
d. Water	\$ 66,067	44,045			22,022	
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$ 19,283	15,479			3,803	
f. Other ( <i>itemize</i> )	\$ 275,347	183,564			91,782	
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$ 503,139</b>	<b>338,050</b>			<b>165,089</b>	
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 22,137	17,771			4,366	
c. Non-Movable Equipment	\$ 459	368			91	
d. Movable Equipment	\$ 53,828	43,212			10,617	
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$ 76,424</b>	<b>61,351</b>			<b>15,073</b>	
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 51,588	41,413			10,175	
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$ 51,588</b>	<b>41,413</b>			<b>10,175</b>	
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,384,161	1,111,162			272,999	
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 278,887	185,924			92,962	
c. Personal property taxes	\$ 33,253	22,169			11,084	
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$ 1,824,313</b>	<b>1,422,020</b>			<b>402,293</b>	

\* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

## Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	NurseFac-Aids
PLANT SUPPLIES	\$ 9,887		\$ 4,943
PLANT CONTRACT SERVICE LABOR	\$ 15,262		\$ 7,631
ELEVATOR CONTRACT SERVICE	\$ 4,084		\$ 2,042
FIRE/SPRINKLER CONTRACT SERVICE	\$ 3,383		\$ 1,691
LANDSCAPING CONTRACT SERVICE	\$ 4,526		\$ 2,263
SNOW REMOVAL CONTRACT SERVICE	\$ 5,671		\$ 2,835
TRASH REMOVAL CONTRACT SERVICE	\$ 21,607		\$ 10,803
HVAC CONTRACT SERVICE	\$ -		\$ -
SECURITY CONTRACT SERVICE	\$ -		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 110,749		\$ 55,375
PLANT MINOR EQUIPMENT	\$ 5,951		\$ 2,976
RENT AUTO	\$ -		\$ -
RENT EQUIPMENT	\$ 2,445		\$ 1,223
RENT OTHER	\$ -		\$ -
<b>Total Other Repairs and Maintenance</b>	<b>\$ 183,564</b>	<b>\$ -</b>	<b>\$ 91,782</b>

### Depreciation Schedule

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C			Report for Year Ended 9/30/2021			Page 23	of 37		
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
<b>A. Land Improvements</b>												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal												
<b>B. Building and Building Improvements</b>												
1. Acquired prior to this report period			394,955		394,955	132,317			22,137			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
B-4. Subtotal										22,137		
<b>C. Non-Movable Equipment</b>												
1. Acquired prior to this report period			7,990		7,990	6,767			459			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal										459		
		Is a mileage logbook maintained?	Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year							
<b>D. Movable Equipment</b>												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a. Van Repair: Hillside Automotive Center					9,580		13,085	12,014			1,071	
b. Van Repair: Hillside Automotive Center				8	2018	3,505						
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					648,058		648,058	483,131			51,611	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					18,482						1,146	
D-3. Subtotal												53,828
<b>E. Total Depreciation</b>												76,424

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Land Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Land Improvements</b>		\$ -		\$ - **

\*Ties to Page 23, Line A3

\*\*Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Building Improvements</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2





**Annual Report of Long-Term Care Facility**

**Amortization Schedule\***

Name of Facility Trinity Hill Care Center, LLC			License No. 2222-C		Report for Year Ended 9/30/2021			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period				943,343	587,300			51,284	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				6,636				304	
C-4. Subtotal									51,588
<b>D. Total Amortization</b>									51,588

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

**C. Expenditures Other Than Salaries (cont'd) - Property Questionnaire**

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2021	Page 25	of 37
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11. Property Questionnaire

**Part A**

Is the property either owned by the Facility or leased from a Related Party?\*

Yes  No

If "Yes," complete Part B.  
If "No," complete Part C.

\*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	04/01/99
3. If <b>NOT</b> Original Owner, Date of Purchase	04/01/99
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	144
6. Square Footage	51,572
7. Acquisition Cost	
a. Land	
b. Building	

**Part B - Owner and Related Parties**

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
--	--------------	--------------	--------------	--------------

1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

**Part C - Arms-Length Leases for Real Property Improvements Only**

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
Summit Trinity Hill SNF, LLC	151 Hillside Ave, Hartford, CT	08/09/17	15 year with 2	1,396,000

**Note:** Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

**C. Expenditures Other Than Salaries (cont'd) - Interest**

Name of Facility		License No.	Report for Year Ended		Page	of
Trinity Hill Care Center, LLC		2222-C	9/30/2021		26	37
Item			Total	CCNH	RHNS	NurseFac-Aids
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)			\$			

*(Carry Subtotals forward to next page)*

**C. Expenditures Other Than Salaries (cont'd) - Interest and Insurance**

Name of Facility		License No.		Report for Year Ended			Page	of
Trinity Hill Care Center, LLC		2222-C		9/30/2021			27	37
Item				Total	CCNH	RHNS	NurseFac-Aids	
Subtotals Brought Forward:								
12. C. Movable Equipment								
1. Automotive Equipment				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
2. Other ( <i>Specify</i> )				\$				
A. Item		Rate	Amount					
Lender								
Address of Lender								
B. Item		Rate	Amount					
Lender								
Address of Lender								
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$				
12. D. Other Interest Expense ( <i>Specify</i> )				\$				
INTEREST								
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$				
14. Insurance								
a. Insurance on Property (buildings only)				\$	8,299	5,533	2,766	
b. Insurance on Automobiles				\$	2,517	1,678	839	
c. Insurance other than Property (as specified above)								
1. Umbrella ( <i>Blanket Coverage</i> )				\$	94,076	62,717	31,359	
2. Fire and Extended Coverage				\$				
3. Other ( <i>Specify</i> )				\$	13,833	9,222	4,611	
Other insurance, crime								
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$	118,725	79,150	39,575	
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$	14,532,783	11,442,336	3,090,447	

### D. Adjustments to Statement of Expenditures

Name of Facility Trinity Hill Care Center, LLC				License No. 2222-C	Report for Year Ended 9/30/2021	Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
<b>Page 13 - Professional Fees</b>							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	C	Bad Debts	\$ 120,004	120,004		
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m3	Unallowable Advertising *	\$ 7,550	6,061		1,489
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 33,123	26,590		6,533
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
<b>Subtotal (Items 1 - 26)</b>				\$ 160,677	152,655		8,022

\* All except "Help Wanted".

(Carry Subtotal forward to next page)

\*\* Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.



**D. Adjustments to Statement of Expenditures (cont'd)**

Name of Facility				License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC				2222-C	9/30/2021	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	NurseFac-Aids
Subtotals Brought Forward				\$ 160,677	152,655		8,022
<b>Page 20 - Resident Care Supplies***</b>							
27.			Prescription Drugs	\$			
28.	20	5d	Ambulance/Limousine	\$			
29.	20	5f	X-rays, etc	\$ 1,306	1,306		
30.	20	5h	Laboratory	\$ 20,463	20,463		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$			
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$			
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 182,446	174,424		8,022

\*\*\* Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
20	5J	Non Covered PPS Visits	-		-
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)	-		
13	B9A	ST- Resident Care (for outpatient therapy - see schedule)	-		
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)	-		
<b>Total Other Ancillary Costs</b>			\$ -	\$ -	\$ -

**Schedule of Excess Movable Equipment Depreciation**

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	NurseFac-Aids
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ -



<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

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**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended			Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2021			30	37
Item	Total	CCNH	RHNS	NurseFac-Aids		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 13,273,164	10,547,513		2,725,651		
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 440,096	348,409		91,687		
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$ 29,035	29,035				
b. Private-Pay Room and Board Contractual Allowance **	\$					
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 28,423	28,423				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (28,423)	(28,423)				
c. Prescription Drugs - Non-Medicare	\$ 35,905	29,108		6,798		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (35,905)	(29,108)		(6,798)		
2. a. Medical Supplies - Medicare	\$ 187	187				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (187)	(187)				
c. Medical Supplies - Non-Medicare	\$ 4,949	3,627		1,322		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (4,949)	(3,627)		(1,322)		
3. a. Physical Therapy - Medicare	\$ 43,827	43,827				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (26,451)	(26,451)				
c. Physical Therapy - Non-Medicare	\$ 135,168	117,485		17,683		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (135,168)	(117,485)		(17,683)		
4. a. Speech Therapy - Medicare	\$ 6,746	6,746				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (5,825)	(5,825)				
c. Speech Therapy - Non-Medicare	\$ 33,212	28,731		4,481		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (33,212)	(28,731)		(4,481)		
5. a. Occupational Therapy - Medicare	\$ 58,281	58,281				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (27,251)	(27,251)				
c. Occupational Therapy - Non-Medicare	\$ 83,048	74,256		8,792		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (83,047)	(74,255)		(8,792)		
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 607,715	607,715				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 75,994	75,994				
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 14,475,331	11,657,993		2,817,338		
<b>IV. Other Revenue*</b>						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income ( <i>Specify</i> )	\$ 31,882	31,882				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 2,953,364	2,953,364				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 2,985,246	2,985,246				
<b>VI. Total All Revenue</b> (III +V)	\$ 17,460,577	14,643,239		2,817,338		

\* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

\*\* Facility should report all contractual allowances and/or payer discounts.



### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2021	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	3,895,623
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,729,998
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	32,187
5. Prepaid Expenses			\$	251,492
a. Prepaid Insurance	170,903			
b. Prepaid Property Taxes	77,764			
c. Prepaid Expenses Other	2,826			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	(1,294,572)
Due From (to) Related Parties	(12,758)			
Other Owners reserves	(1,281,814)			
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	5,614,727
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
3. Buildings	*Historical Cost	394,955	\$	240,501
	Accum. Depreciation	154,454		Net
4. Leasehold Improvements	*Historical Cost	949,979	\$	311,091
	Accum. Depreciation	638,888		Net
5. Non-Movable Equipment	*Historical Cost	7,990	\$	764
	Accum. Depreciation	7,226		Net
6. Movable Equipment	*Historical Cost	666,540	\$	130,651
	Accum. Depreciation	535,889		Net
7. Motor Vehicles	*Historical Cost	13,085	\$	(0)
	Accum. Depreciation	13,085		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
Construction in Progress				
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	683,007

\* Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
<b>Total Prepaid Expenses</b>			\$ -

Schedule of Other Current Assets (Itemized) Page 31 Line A8

Page Ref	Line Ref	Description	
<b>Total Other Current Assets (Itemize)</b>			\$ -

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref	Line Ref	Description	
<b>Total Other Other Fixed Assets (Itemize)</b>			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
<b>Total Other Assets</b>			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			\$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			\$ -

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2021	32	37
Account			Amount	
Total Brought Forward:			\$	6,297,734
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	743,737
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	49,338
	Patient Trust Funds	46,783		
	Long Term Deposit - primecare	2,555		
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address	Amount	Loan Date		
7. Other Assets ( <i>itemize</i> )			\$	
See Schedule				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	793,075
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	7,090,809

\* Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).



### G. Balance Sheet (cont'd)

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			2,078,786	
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				
				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$
Patient Trust Funds		46,783	46,783	
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 46,783
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 2,125,569

**G. Balance Sheet (cont'd)**  
**Reserves and Net Worth**

Name of Facility	License No.	Report for Year Ended	Page	of
Trinity Hill Care Center, LLC	2222-C	9/30/2021	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	1,000
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	2,036,446
6. Gain or Loss for Period			\$	2,927,794
	10/1/2020	thru 9/30/2021		
7. Total Net Worth			\$	4,965,240
<b>C. Total Reserves and Net Worth</b>			\$	4,965,240
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	7,090,809

### H. Changes in Total Net Worth

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2021	Page 36	of 37	
Account			Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2020			\$		
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$ 17,460,577		
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$ 14,532,783		
D. Net Income or Deficit			\$ 2,927,794		
E. Balance			\$ 2,927,794		
F. Additions					
1. Additional Capital Contributed <i>(itemize)</i>					
2. Other <i>(itemize)</i>					
F-3. Total Additions			\$		
G. Deductions					
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>					
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount		
2. Other Withdrawings <i>(Specify)</i>			\$		
Purpose		Amount			
3. Total Deductions			\$		
H. <b>Balance at End of Period</b>		09/30/21	\$ 2,927,794		

### I. Preparer's/Reviewer's Certification

Name of Facility Trinity Hill Care Center, LLC	License No. 2222-C	Report for Year Ended 9/30/2021	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input checked="" type="checkbox"/> NurseFac-Aids		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
iCare Management, LLC				
Address Address			Phone Number	
341 Bidwell Street, Manchester, CT 06040			860-570-2140	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Kartik Patel			860-570-2140	
Contact Email Address				
Kpatel@icarehn.com				

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